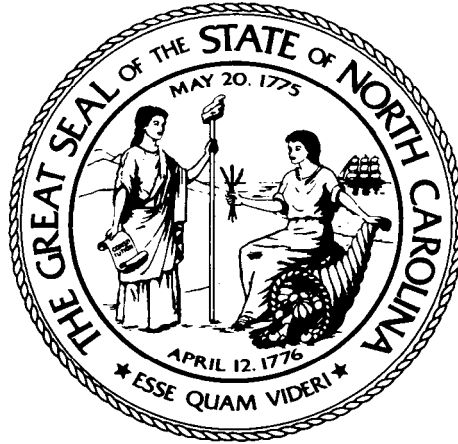


North Carolina Child and Family Leadership Council



January 2007 Report To The

Office of the Governor

Joint Appropriations Committees and Subcommittees on
Education

Joint Appropriations Committees and Subcommittees on
Justice and Public Safety

Joint Appropriations Committees and Subcommittees on
Health and Human Services

Fiscal Research Division of the Legislative Services Office

January 2007

December 20, 2007

Pursuant to Session Law 2005-276, Section 6.24, the North Carolina Child and Family Leadership Council submits its January 2007 Report to the Office of the Governor; the Joint Appropriations Committees and Subcommittees on Education; the Joint Appropriations Committees and Subcommittees on Justice and Public Safety; the Joint Appropriations Committees and Subcommittees on Health and Human Services and the Fiscal Research Division of the Legislative Services Office.

Respectfully Submitted,

The North Carolina Child and Family Leadership Council

PREFACE

The North Carolina Child and Family Leadership Council was established by the General Assembly (Session Law 2005-276) to increase the academic success and reduce out-of-home and out-of-county placements of children at risk of academic failure.

This is the third such report prepared by the Child and Family Leadership Council, and fulfills its legislative mandate to submit a report by January 1, 2007.

This report summarizes the School-based Child and Family Support Team Initiative's authorizing legislation, the implementation process, and the progress made and goals achieved since the July 1, 2006 report.

BACKGROUND

The School-based Child and Family Support Team Initiative (Initiative) is a state-funded initiative designed to meet the needs of at-risk students in publicly-funded Local Education Agencies (LEAs). With its implementation, Governor Mike Easley's leadership in education has expanded to improve the coordination between the state's public schools and child serving agencies in an effort to build a system of education that gives every child every opportunity to succeed, regardless of geographic location or economic condition. Through the Initiative, students who experience personal, family, and social factors that negatively affect their capacity to succeed academically receive strengths-based, family-centered services in order to improve their academic achievement.

LEGISLATIVE HISTORY

The CFST Initiative was authorized by the North Carolina General Assembly through the enactment of Session Law 2005-276, Senate Bill 622, "2005 Appropriations Act"¹. The legislation required the establishment of the Initiative for the purpose of identifying and coordinating appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect academic performance. The legislation required the Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI), the State Board of Education (SBE), the Department of Juvenile Justice and Delinquency Prevention (DJJDP), the Administrative Office of the Courts (AOC), and other state agencies that provide services for children to share responsibility and accountability for improving outcomes for certain at-risk children and their families.

The legislation was approved August 13, 2005 and effective July 1, 2005. It provided \$11 million to support teams comprised of a school nurse and a school social worker in 21 LEAs with 101 schools across the state.

The legislation required the Initiative to be based on the following principles:

- The development of a strong infrastructure of interagency collaboration;
- One child, one team, one plan;
- Individualized strengths-based care;
- Accountability;
- Cultural competence;

¹ A full text version of S.L. 2005-276 is available on-line at <http://www.ncleg.net/Sessions/2005/Bills/Senate/PDF/S622v9.pdf>. A shortened version is available in Attachment A.

- Children at risk of school failure or out-of-home placement may enter the system through any participating agency;
- Services must be specified, delivered, and monitored through a unified Child and Family Plan that is outcome-oriented and evaluation-based;
- Services must be the most efficient in terms of cost and effectiveness and shall be delivered in the most natural settings possible;
- Out-of-home placements for children must be a last resort and shall include concrete plans to bring the children back to a stable, permanent home, their schools, and their community; and
- Families and consumers must be involved in decision making throughout service planning, delivery, and monitoring.

The legislation also required certain activities from publicly funded child serving agencies at both the local and state levels.

Local level responsibilities include:

- The establishment of the Initiative in designated schools;
- The appointment of school nurse and school social worker Child and Family Team Leaders who must identify and screen children who are potentially at risk of academic failure or out-of-home placement due to physical, social, legal, emotional, or developmental factors;
- The appointment of a Care Coordinator by any local management entity, and a Child and Family Teams Facilitator by any department of social services that has a selected school in its catchment area for the purpose of working with the selected schools in their catchment areas and providing required training to school-based personnel.
- Responsibility for developing, convening, and implementing the Child and Family Team Initiative is based on the screening results:
 - School personnel will take the lead role for children and their families whose primary unmet needs are related to academic achievement.
 - Local management entities will take the lead role for children and their families whose primary unmet needs are related to mental health, substance abuse, or developmental disabilities and who meet the established target population criteria.
 - Local departments of public health will take the lead role for those children and their families whose primary unmet needs are health-related.
 - Local departments of social services will take the lead for those children and their families whose primary unmet needs are related to child welfare, abuse, or neglect.
 - Chief district court counselors will take the lead for those children and their families whose primary unmet needs are related to juvenile justice issues.

- A representative from each named or otherwise identified publicly supported children's agency must participate as a member of the Team as needed.
- Team members must coordinate, monitor, and assure the successful implementation of a unified Child and Family Plan.
- School-Based Child and Family Team Leaders are to provide data to the Council for inclusion in their report to the North Carolina General Assembly. That data will include:
 - The number of and other demographic information on children screened and assigned to a team and a description of the services needed by and provided to these children;
 - The number of and information about children assigned to a team who are placed in programs or facilities outside the child's home or outside the child's county and the average length of stay in residential treatment;
 - The amount and source of funds expended to implement the Initiative;
 - Information on how families and consumers are involved in decision making throughout service planning, delivery, and monitoring;
 - Other information as required by the Council to evaluate success in local programs and ensure appropriate outcomes; and
 - Recommendations on needed improvements.
 - The superintendent of each local LEA that has a participating school must either identify an existing cross agency collaborative or council, or shall form a new group, to serve as a local advisory committee to work with the Initiative.
 - The local advisory committee must include the directors of the county departments of social services and health, the directors of the local management entity, the chief district court judge, the chief district court counselor, and representatives of other agencies providing services to children, as designated by the Committee.
 - The members of the Committee must meet as needed to monitor and support the successful implementation of the School-Based Child and Family Team Initiative.

State level responsibilities include:

- The establishment of the North Carolina Child and Family Leadership Council (Council) located within the Department of Administration for organizational and budgetary purposes. (I think the next few bullets need to be sub-bullets of this one.)
- For the purpose of reviewing and advising the Governor in the development of the School-Based Child and Family Team Initiative and ensure the active participation and collaboration in the Initiative by all State agencies and their local counterparts providing services to children in participating counties in order to increase the academic success and reduce out-of-home and out-of-county placements of children at risk of academic failure.

- Co-chaired by the Superintendent of Public Instruction and the Secretary of Health and Human Services
- Council membership must include the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chairman of the State Board of Education, the Director of the Administrative Office of the Courts, and other members as appointed by the Governor.
- Responsibilities are to include:
 - Signing an annual memorandum of agreement (MOA) among the named state agencies to define the purposes of the program and to ensure that program goals are accomplished.
 - Resolving state policy issues, as identified at the local level, which interfere with effective implementation of the School-Based Child and Family Team Initiative.
 - Directing the integration of resources, as needed, to meet goals and ensure that the Initiative promotes the most effective and efficient use of resources and eliminates duplication of effort.
 - Establishing criteria for defining success in local programs and ensure appropriate outcomes.
 - Developing an evaluation process, based on expected outcomes, to ensure the goals and objectives of this Initiative are achieved.
 - Reviewing progress made on integrating policies and resources across State agencies, reaching expected outcomes, and accomplishing other goals.
 - Reporting semiannually, on January 1 and July 1, on progress made and goals achieved to the Office of the Governor, the Joint Appropriations Committees and Subcommittees on Education, Justice and Public Safety, and Health and Human Services, and the Fiscal Research Division of the Legislative Services Office.
- Specific state Departments must collaborate in the development and implementation of the School-Based Child and Family Team Initiative as well as provide all required support to ensure that the Initiative is successful:
 - Secretary of the Department of Health and Human Services
 - Secretary of the Department of Juvenile Justice and Delinquency Prevention
 - Director of the Administrative Office of the Courts
 - Superintendent of Public Instruction

In the 2006 session of the General Assembly, the Initiative was strengthened through the allocation of recurring state funding in the June 30, 2006 “Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets.” The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services received \$523,638.00 for the 18 local management entities having Initiative sites in their catchment areas to hire 18 care coordinators to work with Child and Family Teams. The Division of Social Services received \$420,804.00. Twelve (12) county Departments of Social Services

(Anson, Bertie, Duplin, Greene, Halifax, Hoke, Hyde, McDowell, Martin, Nash, Pamlico and Vance) were allocated funding to hire facilitators to support the Initiative sites in their counties.

KEY POINTS OF IMPLEMENTATION

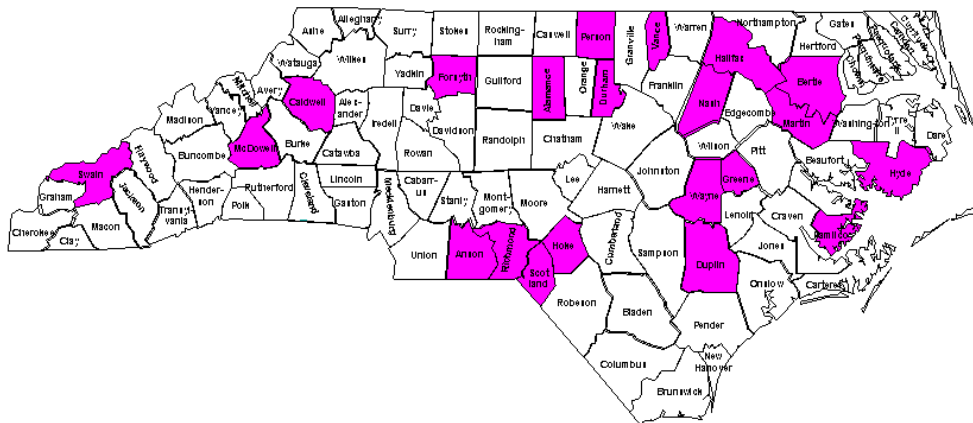
1) All Legislated Responsibilities Have Been Fulfilled

***Legislated Responsibility #1:** Establish the Initiative at designated schools and appoint the school nurses and school social workers Child and Family Team Leaders.*

In January 2006, 21 pilot LEAs were selected to participate in the Initiative². Sites were selected based on the following criteria:

- Identified needs of children and families in selected schools;
- Demonstrated commitment of the school system and their health, mental health and social service partners to work together to address the needs of children and families
- Geographic diversity statewide; and
- Readiness to implement at the community and school level.

Each selected site had an average of five schools with school nurse/school social worker teams. The minimum number of Teams in an LEA was 2 (Hyde County Schools) with several LEAs having 6 or 7 Teams. The map below identifies the 21 selected LEAs.



The authorizing legislation required that the Initiative be established through the appointment of school nurse and school social worker CFST Leaders. Existing

² See Attachment B: “List of Selected Local Education Agencies and Schools” for the complete list.

regulations the Department of Public Instruction required that the social workers be licensed as school social workers through DPI, and the nurses be nationally certified as school nurses. This was accomplished by providing funding through the most appropriate state agencies. The funding provided \$51,000 per social worker and \$50,000 per nurse. Approximately \$5,000 per CFST Team (nurse and social worker) was also allocated through the Department of Public Instruction to help the LEAs provide for start up and operational costs.

Originally, funding for the school social workers was administered by the Department of Public Instruction through the addition of Initiative specific program and object codes to its established funding system. Funding for school nurses was administered through contracts established between the 21 individual LEAs and the Department of Health and Human Services/Division of Public Health. This required each LEA to submit monthly expenditure reports to the Program Coordinator in order to receive reimbursement for the nurses' salary and fringe expenses incurred the previous month.

Beginning in July 2006 the nurses' salary and fringe expenses were administered through a contractual relationship between the Department of Health and Human Services/Division of Public Health and the Department of Public Instruction. It allowed DPI to function as the fiscal agent of \$5,000,000 transferred from the North Carolina Department of Health and Human Services/Division of Public Health for the sole purpose of administering and monitoring funding to the 21 selected LEA's sufficient to enable the LEAs. DPI has added CFST nurse specific program and object codes to its established funding system in order to meet the programmatic and monitoring needs of the agencies involved. Through this collaborative relationship the 21 LEAs no longer are required to submit monthly expenditure reports while still required to meet all the Initiative's legislative and programmatic requirements. It has also provided the LEAs with greater capacity to employ the most qualified nursing staff.

The LEAs were authorized to begin hiring staff as early as March 2006, and began hiring in June 2006. In 19 LEAs (Alamance/Burlington, Anson, Bertie, Caldwell, Duplin, Winston-Salem/Forsyth, Greene, Halifax, Hoke, Hyde, Martin, McDowell, Nash/Rocky Mount, Pamlico, Person, Richmond, Scotland, Swain, and Vance) all nurses and social workers are employees of the LEAs. In Wayne Public Schools the social workers are employees of the LEA, and the nurses are provided through a contract with Wayne Memorial Hospital. In Durham Public Schools, the social workers are provided through a contract with the Durham County Department of Social Services and the nurses through one with the Durham County Health Department. The LEAs were fully staffed and operational by the start of the 2006-2007 traditional school year.

Legislated Responsibility #2: *Appoint a Care Coordinator from each local management entity, and a Child and Family Teams Facilitator from each department of social services that has a selected school in its catchment area.*

This was originally accomplished with no additional funding through the efforts of management from the Division of Social Services and Division of Mental Health/Substance Abuse Services/Developmental Disabilities working in collaboration with their local departments of social services and management entities. Prior to funding provided by the June 30, 2006 “Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets” every Local Management Entity and Department of Social Services had appointed specific people to serve as care coordinators and facilitators. In each agency these appointments were members of their existing staffs who had responsibilities in their agencies, in addition to those of the Initiative. These appointments strengthened already established, effective local infrastructures of educational, health and human services resources in the community.

As stated above, the June 30, 2006 “Joint Conference Committee Report on the Continuation, Expansion and Capital Budgets” allocated recurring state funds to establish these positions in the LMEs and DSSs. The funding has been allocated to the local LME and DSS agencies, positions posted and the hiring process begun. Until new care coordinators and facilitators are hired those originally appointed continue to fully support the Initiative as legislatively required.

Legislated Responsibility #3: *Identify an existing cross agency collaborative or council, or form a new group, to serve as a local advisory committee to work with the Initiative.*

There is no change in this since the July 2006 report. Each LEA has created its committee and they are functioning as required by statute. Most of the sites utilize committees they already had in existence. These most frequently are their legislatively required School Health Advisory Committees (SHACs). Others created planning and advisory committees to collaborate in applying for the Initiative, and left them intact and functioning once selected. At least one LEA (Durham) is using its existing System of Care Steering Committee to fulfill this function.

The committees are required to meet as often as necessary to support the successful implementation of the Initiative, as well as enter into local memorandums of agreement (MOA) on an annual basis. A model MOA may be found at the end of this report in Attachment C.

Legislated Responsibility #4: *Develop an evaluation process, based on expected outcomes, to ensure the goals and objectives of this Initiative are achieved.*

Duke University’s Center for Child and Family Policy (CCFP) has been contracted to conduct the evaluation required by legislation. A contract has been executed between the CCFP and the Department of Health and Human Services for this purpose. The CCFP

has developed an evaluation and implementation process in partnership with the Department of Health and Human Services, the Department of Public Instruction, and the Local Education Agencies that focuses on the implementation of the Initiative at the State and local levels. The plan for evaluation of the Initiative follows the participatory action research model, which involves all relevant stakeholders in actively collaborating to examine current action in order to change and improve it. This evaluation is designed to address the specific issues identified by State and local staff and practitioners, and apply the results directly to the identified problems at hand. This includes design, methods, implementation forms, periodic review and feedback, and a final report. It uses the information and learning obtained throughout this project to create an environment of continuous learning, address the underlying systemic issues that effect the outcomes for children, families, and community agencies; and provide the impetus and knowledge to make necessary system change.

The evaluation involves tracking many outcomes from various sources of data. It measures outcomes at the child, school and system level. Questions and issues that the evaluation addresses include the following:

- A description of the youth who are served by Child and Family Teams (grade, gender, referring problem, services received).
- A comparison of educational outcomes for schools in the Child and Family Support Team Initiative and comparison schools that are not part of the Initiative.
- An examination of changes in educational outcomes and out-of-home placements for youth before and after they entered the Child and Family Support Team Initiative.
- An examination of the effects of the program on a) student's access to health care, mental health care and social services; b) student, teacher, parent, school administrator, local agency perceptions of the CFST process; and c) interagency collaboration in the community.

A description of the outcomes by source of data is below, and also discusses the work that is involved with using each data source.

- Administrative Data from North Carolina Education Data Center The North Carolina Education Data includes information on all North Carolina public school students, grades 3 through 12. This data will provide information on the following outcomes.
 - End of Grade Exams: End of Grade exams are given in reading and math in grades 3 through 8 and available for all students. Data include records for students who are absent or exempt from the test for various reasons. If a student took a retest, either because they failed it initially or for some other reason, such information is included in a separate student record within the file.
 - Number of days not in violation (similar to school absences): School attendance is not always complete in the dataset provided by the

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Department of Public Instruction. Instead, a measure that is sometimes used is in “Number of school days not in violation of the 10-day rule.” Students with 10 or more consecutive unexcused absences are in violation of the 10-day rule.

- Grade Retention: DPI does not provide information about whether students are retained in grade. However, because student data can be linked across years, the evaluation will be able to determine whether a student is enrolled in the same grade across successive years. Thus, the evaluation will provide information pertaining to grade retention, and whether this varies according to participation in the Child and Family Support Team Initiative.
- School Drop Out: The ability to identify youth who drop out of school is somewhat limited because individuals who are not in the dataset may have enrolled in a private or parochial school, moved out of state or dropped out.
- Offenses and Consequences: Beginning in the 2000-01 school year, NC Department of Public Instruction required schools to report students who committed infractions leading to out-of-school suspension, referral to an Alternative Learning Program or expulsion and any infraction that must be reported to the police (such as drug possession) regardless of outcome. These data include records of the type of offense committed and the school’s response to that offense.
- Administrative Data from the Departments of Social Services and Department of Juvenile Justice and Delinquency Prevention: Data from the Department of Social Services and Juvenile Justice and Delinquency Prevention can provide information on out-of-home placement, the reason for placement, length of stay, and prior experience in the system. These datasets do not include information on which school the youth attended. However, they do contain the youth’s name, birth date and gender. Using these characteristics, we may be able to link information from the North Carolina Education Data Center to the data contained in these sources. The value of this combined dataset is evidenced by the fact that it represents the only source of information on out-of-home placements for youth who are not served by Child and Family Support Teams.

- Survey Data

For certain outcomes of interest participants will be questioned directly through a short survey. The following groups of individuals will be surveyed on the topics listed below:

- Students who are involved in a CFST: A statistically significant sample of students who participate in CFSTs will be asked about their perceptions of the Child and Family Support Team. Students will be asked whether they felt as though being part of a Child and Family Support Team helped them

- achieve their goals. Also, these students will be asked what the important component of the program was to them, and what additional services might have been helpful.
- Parents who participated in a CFST: A statistically significant sample of parents whose child was referred to a Child and Family Team will be surveyed to learn their perceptions of the program, how involved they felt in decisions regarding care for their child and what if anything could have made involvement in the Child and Family Support Team process better.
 - Principals and other school officials: Two tools will be utilized to survey 100 % of school principals. The first will assess the readiness of the school to adopt a new system. The second will be a satisfaction survey, asking school officials about their perceptions of the program.
 - School Readiness for Child and Family Support Teams
 - Program Satisfaction Survey
 - Social Workers and Nurses: 100% of the social workers and nurses will be surveyed as the primary source of information regarding the number of students who are referred to the child and family support team, how these students are served, and their progress through the system. Information concerning the social workers' and nurses' thoughts regarding their perceptions of the program effectiveness will also be collected.
 - Community Agencies: Key personnel at community agencies in each participating Local Education Agency's catchment area will also be surveyed. The evaluation will ask about their perceptions about whether interagency collaboration has increased and resulted in better care coordination on behalf of the youth.
- The evaluation team will produce the following products on an ongoing basis with final products delivered by April 30, 2007:
 - A database including data collected by the evaluation team throughout this ongoing process.
 - A preliminary draft of the Evaluation report for review by the Contract Administrator. Following review, changes and modifications will be incorporated into a final report, and incorporated into the Council's July 2007 report.
 - Copies of the final report will be prepared and delivered to the CFST Program Coordinator. This report will include:
 - Description of how the evaluation was designed and executed
 - Summary of the findings of each data source
 - Results from the surveys
 - Results from the evaluation
 - Recommendations for improving the project or the evaluation effort based upon the results of the study as well as lessons learned throughout the project.

Since the July 2006 report the evaluation team has collaborated with the Program Coordinator and the CFST sites to develop CFST case management forms, as well as a web based data collection and automated case management system. A list and description of the forms is:

- Referral - Any individual who is concerned about the child can fill out this form to refer the student to a CFST.
- School Record - Used both as a pre-assessment form and as a way to monitor the youth's progress in school. It is used to extract information from the student's official school records.
- Assessment Form - This form is used to determine the student's needs and appropriate next steps following a referral.
- School Nurse Assessment Form - Used to collect information on allergies, height, weight and medical needs.
- Family Member and Contact Information - Collects contact information on individuals who live with the student as well as key individuals in the student's life who may be part of a CFST.
- Family Confidential Information - Collects contact information on individuals who live with the student as well as key individuals in the student's life who may be part of a CFST.
- CFST Meeting - Indicates the date and time of the meeting as well as individual's who attended the meeting.
- Household Information - Collects basic information about the student's household such as number of adults and children living in the house.
- Agency Events - Documents the student's previous experiences with foster care, child protection services, juvenile justice, mental health and other community agencies.
- Life events - Documents life experiences that the student may have experienced including change in residence, change in school, death of a family member, separation/divorce of parents to name a few.
- Out-of-home placements - Documents each time a student has been placed in a foster home, institutional setting or otherwise placed out of his or her home.
- Service Plan - Indicates the plan that the CFST creates following a CFST meeting.
- Service - Tracks whether the student received recommended services.
- Progress Report - Monitors the student's progress following a CFST meeting.
- Case Close - Used for every child who has been referred to a CFST to indicate why the child is not currently involved in a CFST.
- CFST Meeting Confidentiality
- CFST Consent to Release Confidential Information

The CFST nurses and social workers are not required to use all forms on every case. They use the forms that apply to the individual case on an as needed basis. The forms are available in Adobe pdf as well as Microsoft Word versions to authorized users through a web site established by the evaluation team. The web site is password protected and located at <http://www.duke.edu/web/cfst-eval/index.html>. The web site not only supports

the Initiative through its provision of the forms but by also providing “listserv” capacity where registered users may make inquiries concerning the Initiative or its evaluation at cfst-leaders@duke.edu, a “frequently asked questions” link where users may find answers to questions already asked and answered, as well as a summary of the evaluation, information concerning the evaluation team, and a link to the web based case management system.

The case management system was created by the evaluation team as part of their contract with the Initiative and is only accessible to registered users. It was on line and accessible to users in October 2006. It is being accessed by registered CFST leader users through a link provided on the web site referenced above, and is being used to enter information they have gathered since they began receiving referrals. The system allows for the collection of all data necessary for the evaluation as well as provides the CFST staff with a web based case management system.

The evaluation team also provides technical assistance through e-mail contact as well as by telephone. The CFST leaders have been provided contact information for each member of the evaluation team and invited to make contact as soon as the need arises. Technical assistance is also provided by the evaluation team through their regular presence at CFST meetings and training sessions.

Legislated Responsibility #5: Establish the North Carolina Child and Family Leadership Council (Council)

As stated in the July 2006 report, the Council has been established according to the legislative requirement for the purpose of advising the Governor in the development of the Child and Family Support Team Initiative and to ensuring the active participation and collaboration in the Initiative by all State agencies and their local counterparts providing services to children in participating counties in order to increase the academic success of participating students. The Council is co-chaired by the Superintendent of Public Instruction and the Secretary of the Department of Health and Human Services, with membership drawn from the highest levels of state agencies that address the educational, health and human services needs of children.

2) Program Training has been Provided

CFST training has been provided by the Program Coordinator as well as the Family Group Conferencing Project of North Carolina State University. Training sessions provided by the Program Coordinator began in June 2006 and are planned to continue throughout the existence of the Initiative.

The first stage of training was designed to provide information concerning CFST Orientation and Implementation in the LEAs and individual schools. Its target audience included principals and other LEA staff; as well as staff from the local management entity, health department, social services, and juvenile court systems. The training was

provided as 2 one-day, regional events during the months of June. One session was held in Forsyth county and the other in Wayne. The training provided participants with necessary information to successfully support the implementation of the Initiative in their communities and schools. Training topics included:

- Background and goals of program
- Local advisory committee - representation, role, meeting schedule
- Roles of the CFST Leader nurses and social workers in school environment
- Year round coverage of the CFST Leader nurses and social workers
- Administrative and clinical supervision of the CFST Leader nurses and social workers
- Marketing of the CFST - including how it relates to system of care or other similar initiatives, and strategies on how to blend programs
- Training and evaluation plans
- Regional meetings
- Roles of other agencies

The second stage of training was specifically targeted at meeting the programmatic needs of the CFST Leader nurses and social workers. This also included central office staff and other significant LEA contacts. It was required training for the CFST nurses and social workers, and delivered regionally beginning on August 22nd in Wayne County and ending September 8th in McDowell County. The sessions extended into September at the request of the host sites due to local schedules and the availability of meeting space. The training was provided regionally in 4 two-day sessions. The training sites included Richmond, Alamance, McDowell, and Wayne Counties. Approximately 300 people received training during these sessions. Training topics included:

- The connection between coordinated school health and the Initiative
- Background and goals of the Initiative
- Appropriate referrals and screening
- Strengths-based assessments
- Child and Family Support Team Model
- Roles of the CFST Leader nurses and social workers in school environment
- Evaluation and use of case management forms

Beginning on September 12th, the Program Coordinator began making site visits to each of the 21 LEAs. The purpose of the visits was to systematically and individually assess each LEA as it began to implement the Initiative. This was done early in the school year to allow for programmatic and practice revisions to be made if needed, while lessening their impact on the students, their families, schools, and LEAs as much as possible. Issues handled during these visits included assuring that all local stakeholders were aware of the purpose and goals of the Initiative, as well as how their agencies fit into it. The Program Coordinator either conducted individual interviews or focus groups with all superintendents, principals, CFST nurses and social workers, as well as LEA central

office staff and community partners. These visits allowed local staff members the opportunity to ask questions of the Program Coordinator they either may not have felt comfortable asking in the more public regional meetings, or did not have the experience yet to know what to ask. The last site visit was made in Bertie County on November 9th. Site visits are being planned for all 21 LEAs again beginning after January 2007 to provide necessary program oversight and individual consultation.

Beginning November 15th, training will be provided to the CFST nurses and social workers through a series of bi-monthly regional meetings. These required meetings are planned for November, January, March, and May. In November there were four meetings, while five are planned during each of the other months. These are 1-day events providing opportunities for joint learning by participants. Topics will include CFST evaluation and the use of the web based case management system, LME and DSS connections to the Initiative, domestic violence and its impact on children, and methamphetamine production and what LEA staff should be aware of to protect themselves as they visit families in their homes. These meetings will also provide opportunities for participants to be updated on issues relevant to the Initiative, and share their experience working with families with one another.

About 50% of the CFST nurses and social workers have received training from North Carolina State University's Family Group Conferencing Project on issues concerning how to plan and hold Child and Family Support Team Meetings. The training consisted of three multiple day sessions per week for three weeks, and therefore required the participants to be away from their LEAs during training. Training was provided at no cost, except for that related to travel, as the result of a contractual relationship between the Division of Social Services and the NCSU. Topics included the basics of a family meeting, how to organize family meetings logistically, how to facilitate family meetings, and how to involve children in them. The sessions were evaluated by post-training surveys and received high marks for content and usefulness of the information presented. The training calendar begins again in January and those CFST nurses and social workers who were not able to attend from July to December will have an opportunity to do so before the end of the 2007 school year. This training is not required of the CFST nurses or social workers.

The Program Coordinator continues to engage in discussions regarding training with three university partners (North Carolina State University's Family Group Conferencing Project, Appalachian State University's Appalachian Family Innovations, and the Center for Youth, Family, & Community Partnerships at the University of North Carolina, Greensboro). These nationally recognized agencies have the capacity to provide training in areas such as family and community engagement, family meetings, and developing and monitoring collaborative plans.

Some LEAs have also engaged local resources, particularly those connected to the Division of Mental Health's System of Care and the Division of Social Services'

Multiple Response System to assist them in understanding the principles of family centered practice and community collaboration.

CFST nurses who have not received training specific to school nursing were required to attend a 2-day training session, “New School Nurse Orientation” provided by the UNC School of Public Health in collaboration with the Division of Public Health. Due to significant instructional revisions, it was also required of any nurse who had not attended it within the last five years. This training was offered in two sessions, each lasting two days during the month of October.

3) The Initiative is Accomplishing its Legislated Purpose

The authorizing legislation stated that the “purpose of the Initiative is to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect academic performance.” To accomplish this the CFST nurses and social workers are charged with the responsibility of identifying students at risk of academic failure or out-of-home placement, conducting holistic assessments of the students’ situations, then coordinating the provision of services to meet the identified needs.

Nurses and social workers have used a variety of means to identify at-risk students. Some have used a thorough review of student health and academic records to match end-of-year and end-of-course test scores with absences, discipline referrals, suspensions, health issues such as asthma and diabetes, and free/reduced school lunches. Others met with principals and other school staff over the summer, or at the beginning of the school year to identify the students each stakeholder believed to be at risk. Some CFST nurses and social workers in middle and high schools went to the elementary and middle schools feeding into their own, and asked the principals and other student support staff members which students they believed would be most at-risk in a new school when the academic year began. As a result, the CFST staff members now report carrying case loads ranging between 6 and 50. They seem to be averaging about 20 cases per team per school.

The service needs of the students range from common medical/health related issues such as eyeglasses and untreated dental decay to severe mental illness. During focus groups and individual interviews, superintendents and principals in the selected schools were asked to identify the issues that most negatively impact the academic success of the students in their schools. Their responses illustrate the complexity of the issues facing at-risk students and their families. They are also representative of the issues identified as causing children to be at-risk by the CFST nurses and social workers. The list is below and in no certain order:

- Homelessness
- Pregnancies complicated by poverty

- Children being raised by relatives (usually grandparents) who are not fully capable of providing care or engaging schools.
- Low family values of education due to a inter-generational history of educational failure
- Drop outs
- Lack of parental involvement, knowledge, and skills
- Transient men in the homes
- Mental illness and the connected lack of mental health services
- Incarceration of parents
- Domestic violence
- Substance abuse
- No skills in resolving conflict
- Single parent families working two jobs creates latch-key children and children raising their siblings
- Gypsy-type families that move frequently
- Families that rely on the medical services of the school because they have no medical home
- Growing Hispanic population creates a barrier to effective communication as parents rarely know English
- Disconnection between teachers and parents
- Narrow focus of teachers on identifying academic negatives and fixing them prevents them from holistically seeing the strengths of the student in other domains of concern
- Community violence
- Retained in grade multiple years

It is important to note that the Initiative is strengthened by principals and superintendents who not only understand the barriers faced by their students and families, but who are also passionate advocates for their students' success. It is evident through conversation with, and observation of, these administrators that no one wants their students to succeed more than they do. The principals' desire for student success has been a major contributor to the success the CFST nurses and social workers have had in conducting assessments of students' needs, as well as coordinate the provision of services. It is best illustrated through the responses of superintendents and principals when asked what impact they see the CFST has had on the children themselves, their families, or the teachers and school community as a whole. Some of those responses include:

- "In response to your question, now I don't know how we functioned as a school without a CFST. Their presence has had an impact on the entire school. The children interact well with them, the families are calling on them and beginning to forge those trust relationships and the faculty and staff members feel that they are added resources with much expertise and talent to offer."

- “The children seem happier to know they can have their physical and emotional needs addressed in an abrupt manner. Parents have been pleased with the depth of knowledge our nurse and social worker possess. Parents also feel confident in the collaborative effort the CFST has given in attending to their children’s needs. The CFST has been instrumental in taking on health and social issues that has allowed me (in my first year as Principal) to continue to address the instructional needs of the children. The CFST has been a tremendous asset for our school and as time passes, their presence will undoubtedly pay great dividends to our school community’s health and well-being.”
- “For years, and before there was research to support such claims, educators have known that many factors external to the school setting greatly affected our students’ abilities to learn. The Child and Family Support Team initiative is the first such tangible effort at supporting these critical aspects of children’s lives. In Swain County, we’re confident that as such support is embedded and sustained, we will see positive long-term benefits in student achievement and school culture, and decreased drop-out rates, teen pregnancy rates, and other undesirable factors impacting our children and their families.”
- “East Elementary’s nurse and social worker are an awesome team. They make home visits weekly and many weeks on a daily basis. They function as a strong liaison between the school and Native American families. Native American children’s needs are being identified and referrals made to the team. The team has been instrumental in children getting into the after school program, students getting eye glasses, children who are tardy or have repetitious absences. This year, they were instrumental in getting help for a family with three children who have slept in class for years. Intervention was sought through DSS by the CFST team to correct this problem. This Care Team also works well with the present counselor and school nurse. They have regular meetings to update each other on the progress of students who have been identified as needing their services. They are an asset to this school and community. I am thankful for their services and the professionalism used by them working with our families.”
- “The Alamance-Burlington School System already feels the positive effects of the Child and Family Team Initiative. All seven schools involved with this initiative have noted a significant impact with the support of a full-time social worker and nurse. The number of students referred for assessment and services has increased significantly in these schools. Contacts with parents, connections with student services staff, and collaboration with community agency personnel, have increased and been strengthened due to the full time presence of a social worker and nurse team. Also, full time nurses and social workers are able to follow-up on concerns immediately on a day-to-day basis with students and parents, rather than waiting until a later date on a school rotation. This has been a major improvement for access to services. Concerns for academic, social, emotional and physical health have been assessed, and plans for services are implemented in a

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much timelier manner...The Child and Family Support Team Initiative has greatly strengthened the quality and quantity of services to students in the Alamance/Burlington School System. This initiative enhances the collaboration among parents, administrators, student services staff, special education, and regular education staff. The initiative allows us to systematically identify, assess, and provide services to those students most in need of support to experience school success.”

The effectiveness of the CFST is also seen in some of the “success stories” provided by the teams. Some of them are below:

- “Thus far, we have had considerable success when facilitating Child and Family Support Team Meetings. We have one case that we consider to be a wonderful success. A sixth grader was referred to the Team from one of the elementary schools. She is a diabetic with a pump. Last year, she had a history of not eating after taking insulin in the mornings and this would cause her blood sugar to bottom out. At other times, she would use her pump to lower her blood sugar so she could go home. She consistently sobbed hysterically at school so her mother would come to get her. Her absences have continued to increase each year, and last year she missed a total of 32 days. Both her grades and her End of Grade test scores have steadily dropped. Her grades had dropped from A’s and B’s to C’s and D’s, and her EOG’s had dropped from 4’s to 3’s. She has suffered not only academically, but socially as well. She is a very capable student who can do well if she attends school and does her work. The CFST scheduled a team meeting on 8-28-06, three days after school started, to assist the student and her family in developing a plan that might help the student get off to a good start and succeed in the Middle School. The mother, step-father, student, nurse and social worker team participated in the meeting, with the principal and assistant principal coming by to meet with the family and offer their support. The CFST nurse/social worker team, along with the family, came up with a plan for keeping the student in school. The plan includes making sure the student eats breakfast and snacks during the school day, checks her blood sugar and keeps a record in the nurse’s office. The plan also includes monitoring of her academic progress and attending the after-school program for tutoring when she gets behind on her work. The student was also referred to the counselor for social issues. After our initial meeting, Sarah came in and was sobbing hysterically trying to get her mother to take her back home. The mother insisted that she stay at school, which was a major milestone. The CFST nurse/social worker kept her in their office, under the direction of the mother, until her blood sugar could be regulated and she could go to class. This episode lasted for about 2 hours, until her blood sugar was regulated and she was emotionally ready to go to class. There was phone communication with the mother throughout the 2 hours. But, with the mother, nurse, and social worker acting as a team, this became the turning point for the student. She has not displayed another episode of sobbing or trying to go home. She has stayed up at night with blood sugar problems and still come in to school.

She is attending school regularly, after-school as needed, and is really blossoming socially. She seems very happy and is so warm and friendly when she comes in to check her blood sugar. We have been able to establish a good relationship with her and her mother. We feel she has great potential to flourish as a middle school student. The Child and Family Support Team approach is a very promising way to empower families in facilitating the success of their children.”

- “The school counselor came to me indicating that the student had been threatening suicide. I met with the mother that afternoon and discussed the situation. Mother was interested in CFST services. A teacher made a referral for CFST. Mother completed paperwork for CFST. The team consisting of the student, mother, 3 teachers, counselor, and nurse met to discuss student’s status. SW assisted mother with a referral for outpatient. Student has started outpatient treatment and has a standing weekly appointment. The team met a second time and a service plan was developed. For the second meeting, mother had requested a smaller number of people to attend the meeting, as she reported feeling intimidated at the last meeting. The mother told SW to invite 2 teachers, 1 counselor, and the student. Mother had concerns about student and her peers on the bus. Therefore, mother found another support. Student now walks a block from school and stays with a minister’s wife until mother gets home. Also, this helps mother to know that student is safe and not harming herself. Student will see a counselor on a regular basis and CFST worker will start making home visits soon to assist with parent education at the request of the mother. Grades are good if student is having a good day. Bad mood equate to bad grades. In talking with the student, she seems to be feeling better about her self-esteem. Student is getting involved in the Drama club and assisting a teacher with developing a scrapbook of the cheerleading squad. Mother is also seeking help for her issues. The two are going to attend family therapy once the therapist feels that it is appropriate.”
- “We started working with the family of a sixth grader in August 2006, before school started. This student has a history of attendance and academic problems. She has been diagnosed with Juvenile Rheumatoid Arthritis and Asthma. In the 5th grade she had 26 absences, 18 of which were unexcused. The school had difficulty getting her mother to participate in school meetings and follow up with medical appointments. Her grades at the end of the 5th grade were 4 F’s, 1 D, and 1 C. The student lives with her mother, 15-year-old sister (who just had a baby), and her sister’s husband. The student’s father died in a car accident in 2003. We have visited the home many times, as well as met with the mother here at school. We have developed a relationship with the student and her family. The nurse was able to meet with the family about the student’s health problems, obtain a release of information from the Doctor’s office for her 504 plan, coordinate and develop, in consultation with her physician, an asthma/health plan for the student at school. The mother calls us anytime there is a problem or information we need to be aware of. This student is currently passing all of her subjects, mostly with A’s and

B's. She has only missed 3 days this year and they have all been excused due to illness and/or Dr. appointments. Her mother even brought her to school one day when she was out sick and had been to the doctor to pick up her work and talk with the social worker because the student was so upset about missing school. This student and her family are happy about her academic success so far this year. We were also able to refer the student's 15-year-old sister, who dropped out of school when she got married, to the Baby Love Program at the Health Department and the Pregnancy Care Center for other services."

- "One success story that we are proud of is regarding two sisters that have had behavioral issues since the beginning of school and their grades reflect their poor behavior. The two girls were both born positive for cocaine at birth and lost their mother a couple years ago as a result of her drug use. The father has raised the girls by himself since they were very young. They were both diagnosed with ADHD a few years ago and have only been given their medication sporadically. The teachers say that the girls are both intelligent, well-behaved students when they are on their medication, but poor students when they do not have their medication. We have been working with this family since the beginning of the school year. We have assisted them in making sure that they get to their doctor's appointments and have acted as a liaison between the father and the teachers. Since then both girls have had their medication every morning. The teachers have commented on their behavior in class and we have seen an improvement in their grades."

The experiences of the local DJJDP staff members connected to the Initiative illustrates that the CFST nurses and social workers are also succeeding in beginning to develop the "strong infrastructure of interagency collaboration" required by the legislation. The state DJJDP asked its Chief District Court Counselors to provide some information concerning the status of the Initiative from their viewpoints. One of the responses illustrates this collaboration:

"This initiative seems to be going very well in the Nash Rocky Mount School district. The Court Counselors have a very good working relationship with the school social workers/nurses. The social workers are on our Community Assessment Team (CAT) which helps with relationship building, collaboration, and communication. The referral process is clear and easy. The school social workers do a great job working with the children and families. They assist us and the family in getting services in place and attend all CFT meetings held for the child regardless of who calls the meeting. When we have a child placed on probation at one of the assigned schools, we immediately refer the child so they can assist us in advocating for that child at their school. This has prevented some suspensions and when suspensions have occurred, the school social workers immediately call a CFT meeting to look at other interventions and strategies to try and meet the child's needs and keep them in school. All in all, the case management by the school social workers is going really well. Counselors are extremely pleased with services being provided."

“All in all, I would say the initiative in my district is going well. We are continuing to work on the administrative (advisory) piece and what our role should be. Need this in more school districts.”

SUMMARY

The Initiative was authorized by legislation and supported by funding in the 2005 session of the General Assembly. LEAs were authorized to hire staff in March of 2006 and completed that process in August of the same year. Most LEAs did not begin accepting referrals until after their nurses and social workers were all hired and received training provided by the Program Coordinator. The LME and DSS agencies have provided adequate support through their appointed care coordinators and facilitators, but have not yet been able to hire all of the newly funded positions. LEAs have convened their local advisory committees and are revising their original memorandums of agreement to capture issues experienced through implementation, or capture the collaboration and participation of new members. The evaluation contract with Duke University’s Center for Child and Family Policy was effective May 2006 and since that time an evaluation plan was finalized, case management forms developed and training provided on their use, a web page was created that includes the capacity to post messages on an list serve, search frequently asked questions, track Initiative activities through a calendar system, and access the web based data collection and case management system (which was activated October 2006). Even though in its beginning practice stages the positive impact of the Initiative has already been seen in the local LEAs, schools, students and families. The most at-risk students in these schools are identified by teams of licensed social workers and certified nurses, individual students and their families are being engaged in strengths-based holistic assessments, and services are being provided through the collaborative efforts of all child serving state agencies partnering with families.

As a result, the purpose of Governor Easley’s Initiative is being fulfilled and is accomplishing its goals of creating a student support system based upon the following principles:

- The development of a strong infrastructure of interagency collaboration;
- One child, one team, one plan;
- Individualized strengths-based care;
- Accountability;
- Cultural competence;
- Children at risk of school failure or out-of-home placement may enter the system through any participating agency;
- Services must be specified, delivered, and monitored through a unified Child and Family Plan that is outcome-oriented and evaluation-based;
- Services must be the most efficient in terms of cost and effectiveness and shall be delivered in the most natural settings possible;

- Out-of-home placements for children must be a last resort and shall include concrete plans to bring the children back to a stable, permanent home, their schools, and their community; and
- Families and consumers must be involved in decision making throughout service planning, delivery, and monitoring.

In the upcoming months, with the growth of the Initiative and advancements in the practice of CFST nurses and social workers, it is fully expected that the capacity of North Carolina's children to succeed in school will continue to be enhanced and strengthened as their physical, social, legal, emotional, or developmental needs are met.

ATTACHMENTS

- A. Legislation Enacting the School Based Child and Family Support Team Initiative
from 2005 General Assembly Session
- B. List of Selected Local Education Agencies and Schools
- C. Model CFST Local Advisory Committee's MOA

Attachment A: Legislation Enacting the Program from 2005 General Assembly Session (SENATE BILL 622)

COLLABORATION AMONG DEPARTMENTS OF ADMINISTRATION, HEALTH AND HUMAN SERVICES, JUVENILE JUSTICE AND DELINQUENCY PREVENTION, AND PUBLIC INSTRUCTION ON SCHOOL-BASED CHILD AND FAMILY TEAM INITIATIVE

SECTION 6.24.(a) School-Based Child and Family Team Initiative established.

(1) Purpose and duties. – There is established the School-Based Child and Family Team Initiative. The purpose of the Initiative is to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect academic performance. The Department of Health and Human Services, the Department of Public Instruction, the State Board of Education, the Department of Juvenile Justice and Delinquency Prevention, the Administrative Office of the Courts, and other State agencies that provide services for children shall share responsibility and accountability to improve outcomes for these children and their families. The Initiative shall be based on the following principles:

- a. The development of a strong infrastructure of interagency collaboration;
- b. One child, one team, one plan;
- c. Individualized strengths-based care;
- d. Accountability;
- e. Cultural competence;
- f. Children at risk of school failure or out-of-home placement may enter the system through any participating agency;
- g. Services shall be specified, delivered, and monitored through a unified Child and Family Plan that is outcome-oriented and evaluation-based;
- h. Services shall be the most efficient in terms of cost and effectiveness and shall be delivered in the most natural settings possible;
- i. Out-of-home placements for children shall be a last resort and shall include concrete plans to bring the children back to a stable, permanent home, their schools, and their community; and
- j. Families and consumers shall be involved in decision making throughout service planning, delivery, and monitoring.

(2) Program goals and services. – In order to ensure that children receiving services are appropriately served, the affected State and local agencies shall:

- a. Increase capacity in the school setting to address the academic, health, mental health, social, and legal needs of children.
- b. Ensure that children receiving services are screened initially to identify needs and assessed periodically to determine progress and sustained improvement in educational, health, safety, behavioral, and social outcomes.

Attachment A: Legislation Enacting the Program from 2005 General Assembly Session (SENATE BILL 622)

- c. Develop uniform screening mechanisms and a set of outcomes that are shared across affected agencies to measure children's progress in home, school, and community settings.
- d. Promote practices that are known to be effective based upon research or national best practice standards.
- e. Review services provided across affected State agencies to ensure that children's needs are met.
- f. Eliminate cost shifting and facilitate cost-sharing among governmental agencies with respect to service development, service delivery, and monitoring for participating children and their families.
- g. Participate in a local memorandum of agreement signed annually by the participating superintendent of the local LEA, directors of the county departments of social services and health, director of the local management entity, the chief district court judge, and the chief district court counselor.

(3) Local level responsibilities. – In coordination with the North Carolina Child and Family Leadership Council (Council), the local board of education shall establish the School-Based Child and Family Team Initiative (Initiative) at designated schools and shall appoint the Child and Family Team Leaders who shall be a school nurse and a school social worker. Each local management entity that has any selected schools in its catchment area shall appoint a Care Coordinator, and any department of social services that has a selected school in its catchment area shall appoint a Child and Family Teams Facilitator. The Care Coordinators and Child and Family Team Facilitators shall have as their sole responsibility working with the selected schools in their catchment areas and shall provide training to school-based personnel, as required. The Child and Family Team Leaders shall identify and screen children who are potentially at risk of academic failure or out-of-home placement due to physical, social, legal, emotional, or developmental factors. Based on the screening results, responsibility for developing, convening, and implementing the Child and Family Team Initiative is as follows:

- a. School personnel shall take the lead role for those children and their families whose primary unmet needs are related to academic achievement.
- b. The local management entity shall take the lead role for those children and their families whose primary unmet needs are related to mental health, substance abuse, or developmental disabilities and who meet the criteria for the target population established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
- c. The local department of public health shall take the lead role for those children and their families whose primary unmet needs are health-related.
- d. Local departments of social services shall take the lead for those children and their families whose primary unmet needs are related to child welfare, abuse, or neglect.
- e. The chief district court counselor shall take the lead for those children and their families whose primary unmet needs are related to juvenile justice issues.

Attachment A: Legislation Enacting the Program from 2005 General Assembly Session (SENATE BILL 622)

A representative from each named or otherwise identified publicly supported children's agency shall participate as a member of the Team as needed. Team members shall coordinate, monitor, and assure the successful implementation of a unified Child and Family Plan.

(4) Reporting requirements. – School-Based Child and Family Team Leaders shall provide data to the Council for inclusion in their report to the North Carolina General Assembly. The report shall include the following:

- a. The number of and other demographic information on children screened and assigned to a team and a description of the services needed by and provided to these children;
- b. The number of and information about children assigned to a team who are placed in programs or facilities outside the child's home or outside the child's county and the average length of stay in residential treatment;
- c. The amount and source of funds expended to implement the Initiative;
- d. Information on how families and consumers are involved in decision making throughout service planning, delivery, and monitoring;
- e. Other information as required by the Council to evaluate success in local programs and ensure appropriate outcomes; and
- f. Recommendations on needed improvements.

(5) Local advisory committee. – In each county with a participating school, the superintendent of the local LEA shall either identify an existing cross agency collaborative or council, or shall form a new group, to serve as a local advisory committee to work with the Initiative. Newly formed committees shall be chaired by the superintendent and one other member of the committee to be elected by the committee. The local advisory committee shall include the directors of the county departments of social services and health, the directors of the local management entity, the chief district court judge, the chief district court counselor, and representatives of other agencies providing services to children, as designated by the Committee. The members of the Committee shall meet as needed to monitor and support the successful implementation of the School-Based Child and Family Team Initiative.

The Local Child and Family Team Advisory Committee may designate existing cross agency collaboratives or councils as working groups or to provide assistance in accomplishing established goals.

SECTION 6.24.(b) North Carolina Child and Family Leadership Council. –

(1) Leadership Council established; location. – There is established the North Carolina Child and Family Leadership Council (Council). The Council shall be located within the Department of Administration for organizational and budgetary purposes.

Attachment A: Legislation Enacting the Program from 2005 General Assembly Session (SENATE BILL 622)

(2) Purpose. – The purpose of the Council is to review and advise the Governor in the development of the School-Based Child and Family Team Initiative and to ensure the active participation and collaboration in the Initiative by all State agencies and their local counterparts providing services to children in participating counties in order to increase the academic success and reduce out-of-home and out-of-county placements of children at risk of academic failure.

(3) Membership. – The Superintendent of Public Instruction and the Secretary of Health and Human Services shall serve as cochairs of the Council. Council membership shall include the Secretary of the Department of Juvenile Justice and Delinquency Prevention, the Chairman of the State Board of Education, the Director of the Administrative Office of the Courts, and other members as appointed by the Governor.

(4) The Council shall:

- a. Sign an annual memorandum of agreement (MOA) among the named State agencies to define the purposes of the program and to ensure that program goals are accomplished.
- b. Resolve State policy issues, as identified at the local level, which interfere with effective implementation of the School-Based Child and Family Team Initiative.
- c. Direct the integration of resources, as needed, to meet goals and ensure that the Initiative promotes the most effective and efficient use of resources and eliminates duplication of effort.
- d. Establish criteria for defining success in local programs and ensure appropriate outcomes.
- e. Develop an evaluation process, based on expected outcomes, to ensure the goals and objectives of this Initiative are achieved.
- f. Review progress made on integrating policies and resources across State agencies, reaching expected outcomes, and accomplishing other goals.
- g. Report semiannually, on January 1 and July 1, on progress made and goals achieved to the Office of the Governor, the Joint Appropriations Committees and Subcommittees on Education, Justice and Public Safety, and Health and Human Services, and the Fiscal Research Division of the Legislative Services Office.

The Council may designate existing cross agency collaboratives or councils as working groups or to provide assistance in accomplishing established goals.

SECTION 6.24.(c) Department of Health and Human Services. – The Secretary of the Department of Health and Human Services shall ensure that all agencies within the Department collaborate in the development and implementation of the School-Based Child and Family Team Initiative and provide all required support to ensure that the Initiative is successful.

SECTION 6.24.(d) Department of Juvenile Justice and Delinquency Prevention. – The Secretary of the Department of Juvenile Justice and Delinquency Prevention shall ensure

Attachment A: Legislation Enacting the Program from 2005 General Assembly Session (SENATE BILL 622)

that all agencies within the Department collaborate in the development and implementation of the School-Based Child and Family Team Initiative and provide all required support to ensure that the Initiative is successful.

SECTION 6.24.(e) Administrative Office of the Courts. – The Director of the Administrative Office of the Courts shall ensure that the Office collaborates in the development and implementation of the School-Based Child and Family Team Initiative and shall provide all required support to ensure that the Initiative is successful.

SECTION 6.24.(f) Department of Public Instruction. – The Superintendent of Public Instruction shall ensure that the Department collaborates in the development and implementation of the School-Based Child and Family Team Initiative and shall provide all required support to ensure that the Initiative is successful.

Attachment B: List of Selected Local Education Agencies and Schools

LEAs and Schools		LEAs and Schools	
Alamance	<ul style="list-style-type: none"> • Cummings High • Broadview Middle • Andrews Elementary • Eastlawn Elementary • Harvey Newlin Elementary • Graham High • Graham Middle 	Anson	<ul style="list-style-type: none"> • Anson High • Anson Middle • Morven Elementary • Wadesboro Elementary • Wadesboro Primary
Bertie	<ul style="list-style-type: none"> • West Bertie Elementary • Windsor Elementary • Southwestern Middle • C.G. White Middle 	Caldwell	<ul style="list-style-type: none"> • Whitnel Elementary • West Lenoir Elementary • Gamewell Elementary • Gamewell Middle • West Caldwell High
Duplin	<ul style="list-style-type: none"> • James Kenan High • Rose Hill-Magnolia Elementary • Warsaw Elementary • Charity Middle • E.E. Smith Middle • Warsaw Middle 	Durham	<ul style="list-style-type: none"> • Bethesda Elementary • Neal Middle • Southern High • Eastway Elementary • Y.E. Smith Elementary • Lowe's Grove Middle • Hillside High

Attachment B: List of Selected Local Education Agencies and Schools

LEAs and Schools		LEAs and Schools	
Forsyth	<ul style="list-style-type: none"> • Konnoak Elementary • Philo Midle • Parkland High • Ibrahim Elementary • Middle Fork Elementary • Walkertown Middle • Carver High 	Greene (All schools in the county)	<ul style="list-style-type: none"> • Greene Central High • Greene County Middle • Snow Hill Primary • West Greene Elementary
Halifax	<ul style="list-style-type: none"> • Northwest Halifax High • Southeast Halifax High • William R. Davie Middle • Enfield Middle 	Hoke	<ul style="list-style-type: none"> • South Hoke Elementary • West Hoke Elementary • West Hoke Middle • Hoke County High
Hyde (2 teams for 3 campuses)	<ul style="list-style-type: none"> • Mattamuskeet Elementary • Mattamuskeet Middle • Mattamuskeet High 	Martin	<ul style="list-style-type: none"> • E J Hayes Elementary • Williamston Middle • East End Elementary • Roanoke Middle
McDowell	<ul style="list-style-type: none"> • McDowell High • East McDowell Junior High • Nebo Elementary • Eastfield Elementary 	Nash-Rocky Mount	<ul style="list-style-type: none"> • D.S. Johnson Elementary • Williford Elementary • Nash Central Middle • Nash Central High
Pamlico (All schools in the county)	<ul style="list-style-type: none"> • Fred Anderson Elementary • Pamlico County Middle • Pamlico County High • Pamlico County Primary 	Person	<ul style="list-style-type: none"> • Northern Middle • Southern Middle • Person High

Attachment B: List of Selected Local Education Agencies and Schools

LEAs and Schools	LEAs and Schools
<p>Richmond</p> <ul style="list-style-type: none"> • Rohanen Primary • Ashley Chapel Elementary • Hoffman Elementary • Ellerbe Junior High 	<p>Scotland</p> <ul style="list-style-type: none"> • Carver Middle • Sycamore Lane Middle • Laurel Hill Elementary • Wagram Primary • Spring Hill Middle • I.E. Johnson Elementary • North Laurinburg Elementary
<p>Swain (All schools in the county)</p> <ul style="list-style-type: none"> • Swain High • Swain Middle • Swain East Elementary 	<p>Vance (All schools in the county)</p> <ul style="list-style-type: none"> • L.B. Yancey Elementary • Henderson Middle • Southern Vance High • Pinkston Street Elementary • Eaton-Johnson Middle • Northern Vance High
<p>Wayne</p> <ul style="list-style-type: none"> • Spring Creek Elementary • Spring Creek High • North Drive Elementary • Brogden Primary • Grantham School • Carver Elementary 	

Attachment C: Model CFST Local Advisory Committee's MOA

Memorandum of Understanding

Between
_____ **County School System**
And
_____ **County Department of Social Services**
And
_____ **Mental Health**
And
_____ **County Department of Public Health**
And
Department of Juvenile Justice and Delinquency Prevention
And
District Court of Judicial District _____

Regarding School Based Child and Family Support Team Initiative

This Agreement is made and entered into as of the date set forth below, by and between the _____ County School System, _____ County Department of Social Services, _____ Mental Health, _____ County Department of Public Health, Department of Juvenile Justice and Delinquency Prevention, and the District Court of Judicial District _____.

Whereas, North Carolina Session Law 2005-276, the 2005 Appropriations Act, provided Legislative authority and funding for the School Based Child and Family Support Team Initiative, and

Whereas, the purpose of the initiative is to identify and coordinate appropriate community services and supports for children at risk of school failure or out-of home placement in order to address the physical, social, legal, emotional, and developmental factors that affect academic performance, and

Whereas, program funds will be used to support Nurse and Social Worker Child and Family Support Teams to be located at _____ (schools).

Therefore, the signatories of this agreement recognize the _____ (name of local advisory committee) as the advisory body to monitor and support the successful implementation of the School-Based Child and Family Support Team Initiative.

The guiding principles of the Child and Family Support Team Initiative are that children and their families are best served when:

- The agencies that serve them develop strong infrastructures of interagency collaboration;

*North Carolina Child and Family Leadership Council
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- They only work with one team of service providers and make one plan;
- They receive individualized strengths-based care;
- There is a system of accountability for everyone involved in their situations;
- All service providers are culturally competent;
- Any agency involved with the family can make referrals to meet their needs;
- The family and child can receive specific services that meet their individual needs, and are delivered and monitored through a unified, outcome-oriented and evaluation-based Child and Family Plan;
- The services the family and child receive are the most efficient and effective while being delivered in the most natural setting possible;
- Children are only placed out of their homes as a last resort and there are concrete plans to bring them back to a stable, permanent home, their school and their community; and
- Their families and other consumers of services are involved in decision making throughout every aspect of service planning, delivery, and monitoring.

Furthermore, signatories of this agreement, through their participation in the Advisory Committee, agree to:

A. Ensure Children Receiving Services are appropriately served by:

- Increasing capacity in the school setting to address their academic, health, mental health, social, and legal needs;
- Ensuring that when they receive services they are screened initially to identify needs and assessed periodically to determine progress and sustained improvement in educational, health, safety, behavioral, and social outcomes;
- Developing uniform screening mechanisms and a set of outcomes that are shared across affected agencies to measure their progress in home, school, and community settings;
- Promoting practices that are known to be effective based upon research or national best practice standards;
- Reviewing services provided across affected State agencies to ensure that their needs are met;
- Eliminating cost shifting and facilitating cost-sharing among governmental agencies with respect to service development, service delivery, and monitoring for children and families receiving services; and
- Participating in local memorandums of agreement signed annually by the Superintendent of the _____ County School System, Director of the _____ County Department of Social Services, Director of the _____ County Department of Public Health, Director of _____ Mental Health, the Chief District Court Judge, and the Chief District Court Counselor.

B. Evaluation and Outcomes

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Provide information for report to the legislature as identified in Session Law 2005-276, Section 6.26 (4) as follows:

- The number of and other demographic information on children screened and assigned to a team and a description of the services needed by and provided to these children;
- The number of and information about children assigned to a team who are placed in programs or facilities outside the child's home or outside the child's county and the average length of stay in residential treatment;
- The amount and source of funds expended to implement the Initiative;
- Information on how families and consumers are involved in decision making throughout service planning, delivery, and monitoring;
- Other information as required by the Council to evaluate success in local programs and ensure appropriate outcomes; and
- Recommendations on needed improvements.

C. Develop Support for the Child & Family Support Team Initiative

- Educate the public on the needs of children and families through advocacy and media; and
- Make presentations to local boards, commissions and elected officials regarding the Child & Family Support Team Initiative.

D. Discharge Their Respective Responsibilities for the Funded Sites

- Establish the School-Based Child and Family Support Team Initiative at designated schools and appoint the Child and Family Support Team Leaders (a school nurse and a school social worker);
- Local Management Entities will appoint a Care Coordinator;
- Departments of Social Services will appoint a Child and Family Support Teams Facilitator;
- The Care Coordinators' and Child and Family Support Team Facilitators' responsibility is to work with the selected schools in their catchment areas and provide required training to school-based personnel;
- The Child and Family Support Team Leaders will identify and screen children who are potentially at risk of academic failure or out-of-home placement due to: physical, social, legal, emotional, or developmental factors;
- Based on screening results, responsibilities for developing, convening, and implementing the Child and Family Support Team Initiative are as follows:
 1. School personnel shall take the lead role for those children and their families whose primary unmet needs are related to academic achievement.
 2. The Local Management Entity shall take the lead role for those children and their families whose primary unmet needs are related to mental health, substance

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- abuse, or developmental disabilities and who meet the criteria for the target population established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
3. The Department of Public Health shall take the lead role for those children and their families whose primary unmet needs are health-related.
 4. The Department of Social Services shall take the lead for those children and families whose primary unmet needs are related to child welfare, abuse, or neglect.
 5. The Chief District Court Counselor shall take the lead for those children and their families whose primary unmet needs are related to juvenile justice issues; and
- A representative from each named or otherwise identified publicly supported children's agency is required to participate as a member of the Team as needed. Team members will coordinate, monitor, and assure the successful implementation of a Unified Child and Family Plan.

This Memorandum of Understanding will be in effect from the date it is signed until June 30, 2007.

Superintendent, _____ County Schools Date

Director, _____ County Department of Social Services Date

Director, _____ Mental Health Date

Director, _____ County Department of Public Health Date

Department of Juvenile Justice and Delinquency Prevention Date

Chief District Court Judge, Judicial District _____ Date